

Eastman. (Jos.)

With grateful remembrance
of Dr Goudell ~~the author~~

A CASE OF HYSTERECTOMY,

WITH

PRACTICAL COMMENTS ON LAPAROTOMY.

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BY JOSEPH EASTMAN, M. D., INDIANAPOLIS.

Mrs. W., married, age thirty-five, mother of two children, the youngest being five years, consulted me December 28, 1886, concerning an abdominal tumor which she had first noticed about four years previously.

During the two or three months preceding her visit to my office, the tumor had given her much annoyance, becoming painful and tender, especially at her menstrual periods. These complaints were accompanied by more or less hectic symptoms, the temperature running as high as 101° and 102° F., with pulse 100. There was much nausea with deranged digestion.

By the usual methods of examination in such cases, I had no difficulty in excluding all but two conditions, namely, multilocular ovarian cyst, with very short pedicle, or myoma, soft fibroid of the uterus. The uterine cavity measured three inches.

I advised abdominal section and removal of the tumor, whichever kind it should prove to be. The patient could not get consent of her mind to be "cut open" during life, but was anxious to have it done post-mortem. At her next period, however, her suffering and debility became so great that she consented, for her children's and husband's sake, to "make the leap for life."

She was admitted to my private hospital for women on February 1st, and at once put upon preparatory treatment to reduce temperature and control hectic symptoms, etc. In spite of treatment during three days the temperature ranged from 100°-102° F. The secretions and excretions being good as could be expected, on February



3d I opened the abdomen by an incision two inches in length, and plunged a trocar into the tumor. No fluid escaped, but a red blush spread over the surface, characterizing a tapped fibroid. The incision was enlarged, extending to the umbilicus, the tumor turned forward and out of the abdomen; the broad ligaments were clamped, ligated with cobbler's stitch, and separated with the cautery; the pedicle clamped with Eastman's large temporary clamp.¹

A strong elastic ligature was then thrown around the pedicle as low as the vaginal attachment, and then it was severed between the clamp and ligature. A conical-shaped piece of tissue was cut out of the stump, the apex pointing toward the internal os, the base directed upward and outward toward the serous membrane. A cautery iron at blue heat was three times passed through the cervical canal from above downward, for the purpose of destroying mucous membrane and also to assist in drainage from interior of the stump. A dressing forceps was passed through after the cautery, by the aid of which a rubber tube, as large as my little finger, was dragged up to within a half inch of the free peritoneal surface. I expected this tube, by its expansion, to resist shrinkage of the stump.

The elastic ligature was removed and over the tube the stump was stitched with No. 14 iron-dyed silk, the stitches placed in the

¹The clamp, as here shown, is made in two sizes, by Shepard & Dudley, New York, and has the following advantages:

1. It is long enough to enable the assistant holding it to be entirely out of the operator's way.
2. It is strong enough that there need be no fear of its breaking, no matter what force is exerted, purposely or otherwise.
3. It has no complicated machinery to get out of order at a critical moment. "The simplicity of an instrument is a measure of its success."
4. No matter how large the substance grasped, or how small, the pressure is the same at either extremity of the clamping jaws, the latter being so constructed that they will not cut nor allow any substance to slip.
5. It will crush a substance as small as a shoestring, or the base of a tumor six inches in diameter. This is sometimes an advantage where the pedicle is short and more room needed for the ligature.
6. It instantly arrests all communication between the patient and tumor, so that air striking the peritoneal surface of the tumor can not chill the patient—and cold venous blood returning to the large veins is an important source of shock.
7. It instantly arrests all escape of arterial blood, which is sometimes great when we have broken up the partition walls of a cyst to reduce its size, and at the same time, where, as in this case, the pedicle includes the uterus, at the internal os, it clamps the mass so as to reduce the pedicle more than one-half.

(The clamp was shown the Society.)

cobbler's stitch manner, and $\frac{3}{4}$ of an inch from the free peritoneal margin. After ligating the arteries these flaps were brought together by Lembert's sutures, it requiring some twelve of them. The peritoneal cavity was cleaned, a glass drainage tube, going down into Douglas' cul-de-sac, was introduced and the abdominal wound closed with silk sutures.

There was little shock, the temperature never reaching above 101° F., except for about one hour, during the action of the first cathartie, when it reached 102° F.²

COMMENTS.

It will be seen from this report that I used Schroeder's intra-peritoneal method of treating the pedicle, with my addition of inserting the elastic tube through the cervix to expand and resist contraction of the tissues at the seat of the ligatures. I should use the same method again, including drainage, not only because the results were good in this case, but because I believe where it can be done, it is the ideal method. Kieth and Bantock admit that this is the true method, at the same time they get the best per cent. by fastening the pedicle outside. Schroeder, I believe, at the time of his death, had some unpublished statistics, showing a lesser mortality by his intra-peritoneal mode. Formerly the submucous fibroids with pedicle, were the only ones admitting of radical cure by surgical means. Now we make an abdominal incision and remove the *subserous* variety by enucleation, or by hysterectomy, in cases where the exigencies demand it.

I admitted before this operation that I did not know whether I had to deal with a cyst or a myoma. Mr. Tait says the differential diagnosis is extremely difficult. In a conversation with Dr. John Homans, at his private hospital in Boston, on the 2d day of this present month, he said to me: "It can not be done." I fully agree with his opinion as expressed, especially when, as in my case, the uterus could be well defined by vaginal and rectal exploration, the soft myoma enabling the sound to move the uterus without any perceptible movements of the abdominal tumor.

²Tumor was exhibited to Society.

PRACTICAL DEDUCTIONS AS A TEXT FOR WHICH THIS CASE
WAS REPORTED.

This case teaches these lessons: That *exploratory incision* is warranted when the diagnosis can not be clearly made out (and our most experienced abdominal surgeons admit we can never do it with certainty) *provided he who does it is fully prepared to do any operation known to the surgery of the abdomen*, and is able to care for his patient afterwards according to the most approved methods, to detail and provide the same surroundings for his patients as do those operators whose increased personal experience has given them such a low rate of mortality that they unhesitatingly publish their death-roll with their successful operations.

After an experience yielded by seven or eight hundred cases, approximately, of laparotomy for various causes, extending over a period of twenty-three years, Dr. Thomas feels that he can say with truth that he has never once regretted opening the abdomen, and that he has in a dozen cases, at least, deeply regretted not having done so. He, at least, thinks it certain that in the future, explorative abdominal incisions will become the rule in all cases of the following conditions which do not yield to medical means, and concerning the etiology of which there is great doubt: 1, wounds and injuries of the abdominal viscera; 2, intestinal obstructions; 3, *the presence of stones in the bladder or kidneys*; 4, the accumulation of blood, pus, or serous fluid from any source; 5, the existence of a neoplasm in any part of the abdomen; 6, the occurrence of serious organic changes in certain of the viscera of the abdomen, such as the kidneys, the spleen, the uterus, the Fallopian tubes, or the ovaries; 7, ectopic gestation.*

This noted abdominal surgeon has completely cured a number of aggravated cases of ascites after tapping had been repeatedly resorted to, and all hope of recovery given up. He feels justified in assuming the position that in cases of ascites in the female, before the patient has been subjected to the usual practice of repeated tapping with its universally bad results, the most thorough investigation as to the existence of small neoplasms as pathological factors should be made; and if signs of their existence be found,

*Before New York City Medical Society.

exploratory incision should be made with the forlorn hope that relief might be obtained.

I can cite two cases of my own, where exploratory incision as a means of diagnosing abdominal tumors might have been the means of saving two valuable lives. A lady of Peru, Ind., under the care of Drs. Brenton and Higgins (at the time I saw her), had consulted two very eminent operators before she consulted me. Each insisted that the sound passed ten inches into the uterus, and that therefore it passed into the enormous tumor which distended her abdomen from pubes to ensiform cartilage, and hence nothing could be done. She had been tapped once, and three gallons of fluid drawn from her abdomen. During six years she sought the best advice with the view of an operation. When I saw her she was already poisoned by sepsis; pulse 140, temperature 103° F. I was asked to make an exploratory incision. I found a tumor weighing about twenty-two pounds, displacing the pelvic viscera, and in an advanced state of decomposition. It was subserous and pedunculated. The pedicle was small. When I seized the tumor with my hand my fingers pierced it, dragging away a rotten piece, pus dropping from it as I lifted it up. She lived only twenty-four hours. If an exploratory incision had been made even *one* year before, this life might have been saved, for the pedicle was small and the uterine cavity not deeper than four inches. The tumor was exhibited to the Marion County Medical Society, 1885.

Case number two, a lady from Hamilton county had been cared for by a physician of Noblesville. I was asked to see her, with Dr. H. S. Herr, of Westfield, Indiana. Her distended abdomen was very suggestive of ascites. A few days after I saw her she died. No operation was made. These facts of the case were determined by post-mortem. The cyst was found ruptured — probably six months before death, since the abdomen had been that long distended. No doubt was felt that had an exploratory incision been made in proper time, the patient would have had a fair chance of recovery.

I cite these two cases from my own practice in confirmation of Prof. Thomas' views of exploratory incision.

Dr. R. S. Sutton, of Pittsburgh (the Lawson Tait of America), speaks in the following terms of exploratory incision :

" Make a clean cut down to the peritoneum, divide or tear the latter, after making a small opening in it, as one's fancy runs. Introduce the requisite number of fingers or the hand, turn out the intestines on a clean towel, look them over for wounds or obstructions, examine a tumor, or tubes, or ovaries, or uterus, or bladder, kidneys, or liver, or spleen. Having done this carefully, clean out the cavity with gentle sponging or irrigation, carefully return the viscera, carefully close the wound if all has been clean and the cavity of the peritoneum is left dry. I say, you have not done anything that will kill your patient, but you have cleared up the case, possibly saved a life.

" These measures must be observed if success will follow such practice. And when this practice obtains, fewer people will die, and fewer will be hanged for killing them with pistols, guns and dirks. People who die now for want of an ante-mortem examination will be spared the post-mortem, which rarely does the patient any good. Such scenes as a hospital staff turning away from a woman dying from the twisted pedicle of a large ovarian cyst will be no more. Such practice as is witnessed when a doctor sits by and gives opium until the post-mortem reveals the fact that an intestine was shot, or stabbed through, or that an obstruction killed the patient, will vanish."

He then discusses who should do the work in the following strong language :

" The best law any general practitioner can lay down for himself and his patient, in abdominal tumors, is this: If you can't do a radical operation, under proper precautions, do nothing. The patient should be sent to some one prepared for and capable of doing the work. In Europe and in Great Britain this rule prevails practically, and hence prominent operators get many cases, and it is from these men that the improvements in abdominal surgery have emanated. Simple bushwhacking in abdominal surgery is a very poor way to make a reputation. All such cases done in a lifetime will rarely exceed a dozen, and if this dozen comprise all the experience the operator gained up to the time of his demise, it has done humanity very little good. When the work in this country is put out to the men prepared to do it, and the cases are not bungled at the start, then we will have just as good results as are found abroad. When men who have not had special clinical training in abdominal surgery cease to do it, and act for the good of the

patient rather than for something else, then this branch of surgery will do well in this country. The present range of abdominal surgery is very extensive. The liver, gall bladder, spleen, kidneys, urinary bladder, intestines, ovaries, tubes and uterus, are all, under diseased conditions, successfully attacked."

Mr. Tait, in speaking of the danger, care, results, and who should operate, says:

"What I fear, in fact what I already feel, is that the remarkable success which I have had, and of which Professor Byford speaks in such strong terms, is really leading astray those *whose opportunities* have not been as my own, into the belief that the work is *easy, simple, easily acquired and free from risk.* It is not so, and unless those who practice it, choose to follow me in the *rigid precautions* and *immense* care which I give, not only to the mere performance of the operation, *but to the surroundings of my patients* and to every *detail in connection with them,* they will not obtain, they must not expect, the success which I have had. I have said that I fear, in fact, I already feel, that this success of mine is leading people astray, and I want to urge in the name of humanity, as well as for the sake of the art we practice, that there should be less of the indiscriminate rushing into this kind of work which has already been deplored on both sides of the Atlantic."* †

Indiana women are as worthy of successful abdominal surgery as are those in any part of the world. Let us remember, then, that those who have placed laparotomy on a solid foundation were surgeons who had more or less abandoned the general practice of medicine, some of them at a great sacrifice, that they might secure that prime element of success in abdominal surgery—a large personal experience in the work. Booth would not think of playing Hamlet with new support each time. So, those who have published statistics, bad as well as good, demand that their patients shall have specially drilled attendants, whose increased personal experience in the work is a wonderful supplement to the skill and experience of the operator.

* From Journal American Medical Association.

† Italics my own.

THIRTY-THREE CASES OF ABDOMINAL SECTION WITH TWENTY-EIGHT RECOVERIES.—EIGHT CASES ADDED
TO THE REPORT IN TRANSACTIONS, OF WHICH THIS IS A REPRINT.

Number.	Residence.	Medical Attendant.	Age.	Maintained or starved.	Disease.	Operation.	Date.	Hospital.	Pt private.	Recovered.	Died.
1	Carter's Station.	Dr. Sellers.	43	M	Ovarian cyst; 30 lbs.	Left ovary removed.	Nov. 17, 1883	.....	Yes	Yes	Yes
2	Lugookee, Ind.	Dr. Brittain.	25	M	Malignant.	Right ovary removed.	Dec. 20, 1883	.....	Yes	Yes	Yes
3	Indianapolis.	Dr. Maxwell.	18	S	Ovarian cyst; 23 lbs.	Left ovary removed.	April 5, 1884	.....	Yes	Yes	Yes
4	Southport, Ind.	Dr. Graydon.	44	M	Ovarian cyst; 38 lbs.	Left ovary removed.	April 12, 1884	.....	Yes	Yes	Yes
5	Crawfords V Road.	Dr. Eastman.	35	M	Parovarian cyst.	Both ovaries removed.	June, 1884	.....	Yes	Yes	Yes
6	Albany, Ind.	Dr. Murray.	19	S	Cancerous tumor; 25 lbs.	Left ovary removed.	Oct. 25, 1884	.....	Yes	Yes	Yes
7	Indianapolis.	Dr. Eastman.	24	S	Ovarian.	Ov. and tubes removed.	Oct. 26, 1884	.....	Yes	Yes	Yes
8	Crawfordsville.	Dr. Irvin.	26	S	Cystic degeneration.	Rem. of both t'bs and ovs.	March, 4, 1885	.....	Yes	Yes	Yes
9	Sullivan.	Prof. Parvin.	22	S	Metorrhagia.	July 18, 1885	.....	Yes	Yes	Yes	Yes
10	Sharpsville.	Dr. Heath.	36	M	Ovarian cyst; 20 lbs.	Removed tumor.	May 4, 1885	My own	Yes	Yes	Yes
11	Port.	Dr. W. H. Branton.	46	M	Fibroid; 22 lbs.	Rem. of both t'bs and ovs.	Sept. 10, 1885	private	Yes	Yes	Yes
12	Indianapolis.	Dr. C. H. Abbott.	22	S	Ovarian cyst; 12 lbs.	.....	Sept. 20, 1885	private	Yes	Yes	Yes
13	Brazil, Ind.	Dr. T. F. Smith.	35	S	Cystic degeneration.	.....	Sept. 20, 1885	hospital.	Yes	Yes	Yes
14	Hope, Ind.	Boydton & Houghley.	42	M	Hysophilinix.	.....	Nov. 24, 1885	.....	Yes	Yes	Yes
15	Indianapolis.	Dr. Miller.	24	S	Cystic degeneration.	.....	Dec. 12, 1886	.....	Yes	Yes	Yes
16	Brazil.	Dr. J. F. Smith.	30	M	Bernroid cyst.	.....	Dec. 31, 1885	.....	Yes	Yes	Yes
17	Indianapolis.	Dr. J. J. Smith.	32	M	Salpingitis.	.....	May 17, 1886	.....	Yes	Yes	Yes
18	"	Dr. G. W. Vernon.	57	M	Ovarian cyst; 20 lbs.	Right ovary removed.	May 24, 1886	.....	Yes	Yes	Yes
19	"	Dr. A. S. McMurray.	33	S	Cystic degeneration.	Both ovs. and tubes rem.	Aug. 5, 1886	.....	Yes	Yes	Yes
20	Zionsville.	Dr. Duzan.	23	S	.....	.....	Aug. 12, 1886	.....	Yes	Yes	Yes
21	Indianapolis.	Dr. C. E. Wright.	49	M	Endeph. cancer of left ov.	Exploratory incision.	Sept. 9, 1886	.....	Yes	Yes	Yes
22	Orangeville.	Dr. Shirley.	38	M	Surround g rectum.	Removal of both tubes and ovaries.	Sept. 17, 1886	.....	Yes	Yes	Yes
23	Indianapolis.	Dr. Maxwell.	27	M	Salpingitis et ovaritis.	Rem. tubes and ovaries.	Feb. 24, 1887	.....	Yes	Yes	Yes
24	"	Dr. Eastman.	27	M	Ovarian tumor.	Rem. tum. et t. fal. tube.	March 22, 1887	.....	Yes	Yes	Yes
25	"	Dr. Blum.	35	M	Fibroid tum. of ut.	Hysterectomy.	Feb. 3, 1887	.....	Yes	Yes	Yes
26	Montezuma, Iowa.	.....	46	M	Pelvic abscess.	Rem. ½ gal. pus from b'd lig. by abdom. sec.	May 16, 1887	.....	Yes	Yes	Yes
27	Indianapolis.	Dr. Chambers.	26	M	Pelvic abscess.	Same as above 3 in pus.	May 24, 1887	.....	Yes	Yes	Yes
28	"	Dr. Brunnel.	32	S	.....	Rem. ovaries.	May 28, 1887	.....	Yes	Yes	Yes
29	Delphi, Ind.	Dr. Shafter.	28	M	Salpingitis.	Rem. ovs. and tubes.	June 14, 1887	.....	Yes	Yes	Yes
30	Indianapolis.	Dr. Eastman.	65	M	Ovarian tumor; 20 lbs.	Removed tumor.	June 29, 1887	.....	Yes	Yes	Yes
31	Minne.	Dr. Kemper.	30	M	Ovarian tumor; 6 lbs.	Removed tumor.	July 7, 1887	.....	Yes	Yes	Yes
32	Windsor, Ind.	Dr. Chenowith.	29	M	.....	Removed tumor.	July 21, 1887	.....	Yes	Yes	Yes
33	New Augusta.	Dr. Brown.	42	.....	.....	Removed Tumor of ov. 7 lbs.	July 27, 1887	.....	Yes	Yes	Yes

In the accompanying table, cases 1, 2, 3 and 4 were reported in Transactions of Indiana State Society, for 1884.

Case 5 died from erysipelatous peritonitis, in the City Hospital, on the 5th day after the operation. The hospital had been built less than one year; still a case of erysipelas had been treated across the hall, only a few days before the operation. I was informed of this at the post-mortem examination of my patient.

Case 6 died in about twenty-four hours after our efforts, from shock. She had a violent attack of general peritonitis, in February preceding the operation, from which she came near losing her life. After this, the tumor grew rapidly, the operation being a last resort. The words yes, under the word recovery, renders comment unnecessary, except that cases 7, 8, and 9 were reported to the Indiana State Medical Society for 1885, and that my reports of work there have encouraged some practitioners to urge earlier operations, and stop tapping, thus insuring better success; and the success removes, to some extent, the fear heretofore felt by patients in this condition, that an ovariotomy was almost sure death. Others, heretofore silent on the subject of abdominal surgery, have presented the subject to State and county societies. This will aid in educating doctors and patients to the fact that the time for a successful ovariotomy is before the forces of death, plus the operation, are stronger than those of life.

Case No. 20 was really the subject of an exploratory incision to differentiate between a pelvic abcess and an encephaloid mass. It proved to be the latter; the tumor sprang from the left ovary, filled the pelvis, and completely surrounded the rectum, making defecation extremely difficult. The growth was not disturbed, except to get a fragment for microscopic examination. It proved to be typical encephaloid cancer. The wound, five inches in length, healed perfectly. She recovered *entirely* from the operation; but the rectum completely closed, her death occurring two weeks from the date of the operation. I consider an exploratory incision worthy of record, as, in my opinion, it will, in expert hands, be a useful aid in diagnosis, and enable us occasionally to save a human life.

Case 11 is reported in the body of this paper.

This report includes all my abdominal sections. My statistics are like those of most operators, *i. e.*, improved by increased personal experience. My experience has been supplemented by the increased experience of Miss Clementia M. Prough, the nurse who manages my private hospital, and has had charge of the after-treatment of twenty-two cases. True, I saw the operation many times before doing it myself, but it is like the juggler who keeps six balls in the air at a time—it looks simple. Try it; you'll let a few drop. Sufficient time has not yet elapsed to determine the *cure* in some of the cases where I removed small ovaries and tubes. I have, however, photographs and letters from some of them who were confirmed invalids, which are to me most gratifying, especially considering the fact that our text-books, written only a few years ago, consigned these sufferers to a life of incurable invalidism.

Dr. Sutton, of Pittsburgh, has recently given publication of all his abdominal sections including his *death-roll*. Dr. Goodell, of Philadelphia, comes out annually with his "year's work in ovariotomy" always including his death-roll. Dr. Wylie, of New York, is publishing his work with its necrology. Dr. John Homans, of Boston, is publishing his 260 odd operations which will include all fatal cases, with many other interesting features. I recently visited these men and saw them operate. They are specialists. They are doing for our American statistics what Wells, Kieh, Tate, Bantock, Martin, Shroeder, and others did for the statistics of the Old World.

Your honored President, Dr. Kemper, suggested to me yesterday, that the laity were not educated to the advantage of early operating, or to the danger of death from delay. I replied, that the published statistics of men specially equipped for the work, *a larger experience by the few and fewer operations by the many*, will in America, as in the Old World, show such a low rate of mortality that women will no longer defer an operation, but will accept it early, at the hand of the specialist. For despite reckless operating, and more reckless, almost criminal inexperience of those who conduct the after treatment of some cases, I predict that this century will draw to a close, honoring abdominal surgery for its marvelous achievements, not only as the crowning glory of all surgery, but of all science and of all art.

